EDITORIAL

TRAUMA AND IMMEDIATE CARE

In 1973 in England and Wales some 18,000 people died as a result of injuries. The Registrar General’s Statistical review (1975) shows that, of all those who died aged less than 15 years, injuries were the cause in 11%, and in those aged between 15 and 29 years, injuries were responsible for 48% of all deaths. In each succeeding 15-year period, although other causes of death become more important in terms of percentages, the actual numbers resulting from injury still increase. In the total review head injuries with or without an associated fracture of the skull accounted for 35% of the deaths. Fractures of the legs accounted for 18%, principally because of the large mortality following fractures of the upper end of the femur in the elderly. The other major causes of death were internal injuries to the chest, abdomen and pelvis occurring in 14% of those who died.

The management of head and chest injuries has been discussed previously in this Journal (for example Campbell, 1966; Horton, 1976; Teasdale, 1976), but the general problems associated with trauma are of concern to anaesthetists; some are discussed in this issue. In particular, a proposition is made that effective treatment beginning as soon as possible will help reduce the mortality and morbidity seen after injury. The basic alphabet of resuscitation (Airway, Breathing, Circulation) is familiar to most anaesthetists and is as applicable to the uncontrolled trauma of injuries as to the controlled events of elective surgery. Anaesthetists, therefore, have something to offer in both the practice of and training for immediate care of the injured.

The questions as to who should deliver such immediate care and who should be responsible for the necessary training, and as to the value of immediate care, have not yet been answered fully. In the United Kingdom most of this care is given by the ambulance personnel who have, in addition, the responsibility of transporting these patients in addition to the many for whom they provide a “bus” service. Many ambulance men have now received or are receiving more advanced training to cope with the more difficult problems. Regrettably, it appears that the Department of Health and Social Security is unconvinced of the value of advanced training and is advising against the extension of training schemes (Health Note (76) 204). Other schemes are running in various parts of the country. Easton (1970) described the involvement of well-equipped and trained general practitioners in the rescue services in rural areas, whilst Snook (1972) has used an accident flying squad in a larger town. In Los Angeles, immediate care is delivered by “paramedics” recruited from the fire service: in this issue Stewart discusses the care and attention needed if they are to become fully effective. Probably, no one solution is ideal for all communities, and it would be a pity if rigid rules describing what service can be provided for the injured were laid down for all areas. The enthusiasm and skill of any and all interested parties, however, should be encouraged, in the endeavour to reduce the large bill, in terms of both life and money, that must be met following injury.

One further aspect of immediate care has recently received much publicity. At disasters which have often produced scores of injured patients, medical, nursing and other hospital staff have often provided a most valuable immediate care service at the scene. Such care also has the advantage that, if properly organized, early accurate information can be relayed to the hospitals, allowing proper provisions to be made. Whilst such major disasters are relatively
uncommon, each accident department needs to be prepared for such problems. Perhaps the use of accident flying squads will ensure that the appropriate staff are not suddenly called to deal with grossly unfamiliar situations.

The value of immediate care has still to be proven. Research into the various systems in use throughout the world is needed to determine their value in terms of the survival of patients, the reduction of the morbidity of injury and the economics of such services in the context of the total cost to the patient and to society.

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REFERENCES

ERRATUM

REDUCTION OF HYPOXIC PULMONARY VASOCONSTRICTION IN THE DOG DURING ADMINISTRATION OF NITROUS OXIDE

*Br. J. Anaesth.*, 49, 301

Sir,—We have overlooked an error on p. 305 of our paper. Line 32, left hand column, should read “... administration of nitrogen” (not nitrous oxide).

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